



# Exercise Prescription

## Physical Therapy Referral

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Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**Conditions:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Neck pain          | <input type="checkbox"/> Abnormal Posture     | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Abnormal Gait        | <input type="checkbox"/> Hypoglycemia             |
| <input type="checkbox"/> Shoulder Pain      | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Hyperglycemia            |
| <input type="checkbox"/> Hip Pain           | <input type="checkbox"/> Edema                | <input type="checkbox"/> Impaired Fasting Glucose |
| <input type="checkbox"/> Knee Pain          | <input type="checkbox"/> Muscle Wasting       | <input type="checkbox"/> Dysmetabolic Syndrome    |
| <input type="checkbox"/> Osteoarthritis     | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Hypertension             |
| <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Obesity                  |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Insulin Resistant    | <input type="checkbox"/> Hyperlipidemia           |
|   |   | <input type="checkbox"/> Weight Gain              |

**Procedures:** { } PT Evaluate & Treat  
                  { } Metabolic Rx

**Frequency:** 1 2 3 4 5 times per week

**Duration:** 4 5 6 7 8 weeks

**Comments/Precautions/Restrictions:**

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PLEASE SEND COPIES OF TEST RESULTS  
AND RECENT BLOOD WORK

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date